Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.

Ohio | **Bureau of Workers' Compensation**

First Report of an Injury, Occupational Disease or Death

By signing this form, I:
- **Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;**
- **Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;**
- **Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial	Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of birth
Home mailing address	Sex ☐ Male ☐ Female		Number of dependents
City / State / 9-digit ZIP code	Country if different from USA		Department name
Wage rate $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____	What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Regular work hours From _____ To _____
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain.			Occupation or job title

Employer name: Athens-Meigs Educational Service Center
Mailing address (number and street, city or town, state, ZIP code and county): P.O. Box 40, Chauncey, OH 45719
Location, if different from mailing address: 21 Birge Drive, Chauncey, OH 45719
Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified	State where supervised	

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)	Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under the Ohio workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, psychiatric, vocational or social information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's BWC managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature	Date	E-mail address	Telephone number	Work number ( )

Treatment info.

Health-care provider name	Telephone number ( )	Fax number ( )	Initial treatment date
Street address	City / State		9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No

E code	11-digit BWC provider number	Date

Health-care provider signature

Employer info.

Employer policy number 305 0005 1-0	Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm		
Telephone number (740) 797-0064	Fax number (740) 797-0070	E-mail address	Federal ID number 31-1599475 / Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No	Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only
☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title	Date	OSHA case number

BWC-1101 (Rev. 1/31/2011)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets OSHA 301 requirements

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Instructions
- Physician must complete this form when the injured worker is under work restrictions or is temporarily totally disabled.
- You must send or fax a copy of the completed form to the managed care organization (MCO) and a copy given to the injured worker at time of exam.
- You may use any other physician-generated document provided that the substitute document contains, at a minimum, the data elements on the MEDCO-14.
- If injured worker is employed by a self-insuring employer complete this form and mail or fax it to the self-insuring employer.
- List ICD-9 codes for the allowed conditions being treated that prevent return to work.

Fax Note:

To	From
Toll-free phone number	Phone number
Toll-free fax number	Fax number

Injured worker name	Claim number	SSN if claim number unknown	Date of injury
			/ /

Injured worker occupation	Employer name

WORK ACTIVITY

☐ May return to work (RTW) with no restrictions on _____

☐ May RTW with restrictions due to work-related injury/disease from _____ to _____ (complete work/non-work capabilities on the right). Work restrictions apply to work and non-work activity. If restrictions cannot be met at work, then injured worker is recommended to be off work.

The restrictions are ☐ permanent ☐ temporary? If temporary, how long? _____

☐ Is totally disabled from work from _____ to _____.

Please explain in the space provided below why the injured worker is unable to work, due to work-related injury/disease. **List ICD-9 codes for the allowed conditions being treated which prevent return to work.** _____

Estimated RTW date _____

Work/Non-Work Capabilities

% of Workday (8 hr) / Repetitions per hr	None at all 0%	Occasional 1-33% 4-6	Frequent 34-66% 6-12	Continuous 67-100% >12
Lift/Carry				
Up to 10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100 lbs.	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐
Reach below knee	☐	☐	☐	☐
Push/pull	☐	☐	☐	☐
Squat/kneel	☐	☐	☐	☐
Stand/walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
No lifting above shoulders	☐	☐	☐	☐

Hand restrictions ☐ Left ☐ Right
- ☐ Must wear splint
- ☐ No lifting greater than _____ lbs
- ☐ No repetitive activities
- ☐ No work with hot or cold substances

No use of ☐ Left ☐ Right
- ☐ Arm
- ☐ Hand
- ☐ Finger _____
- ☐ Other

☐ Change positions every _____ ☐ Work activity as splint/bandage permits
☐ Avoid driving ☐ Keep wound clean/dry ☐ Limit working to _____ Hrs./Day

Physician's further explanation of work abilities or why the injured worker is unable to perform any work: _____

MMI

Has the work-related injury(s) or occupational disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement): ☐ **Yes** ☐ **No**

▶ ***Note: Periodic medical treatment may still be requested and provided.***

IF YES, give date _____ **IF NO, please explain (attach additional sheet if necessary)**

REHAB

☐ **Check if vocational rehabilitation return to work services are indicated.**

Physician name and address ***(please print, type or stamp)***

Date of this exam	Follow-up appointment Date	Time
/ /	/ /	

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.

Physician signature ***(mandatory)*** | **Date** / /

BWC-3914 (Rev. 12/21/2010)
MEDCO-14

EMPLOYEE INCIDENT AND INJURY REPORT
To be completed by employee
PLEASE PRINT IN INK

CompManagement
Health Systems, Inc.

Injured worker's name_____ Location_____
Employer Name_____
Social security number _____ Gender: ☐ Male ☐ Female
Home address_____ Birth Date_____
City/State/Zip_____ Home telephone no. (____)_____

Date of injury or onset of symptoms_____ Time_____ ☐ am ☐ pm

Where did the accident occur: _____

Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, use additional paper). **Be specific - name any objects or substances involved:**_____
_____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?_____

Did you report this incident to anyone? ☐ Yes ☐ No If not, why not?_____
If yes, to whom did you report it?_____ Title/Position_____
When? Date:_____ Time:_____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):
_____
_____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, pull, laceration
_____
_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe:_____
_____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?_____
Name of Physician, Hospital or Urgent Care _____
If treatment was not sought immediately, explain why:
_____
_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury?
By whom or where?_____
Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:_____

Medical Release

Under current workers' compensation provisions, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, **CompManagement, Health Systems, Inc** or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ Date (required)_____